



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

[Document Identifiers: CMS-301, CMS-317, CMS-319, CMS-8003, CMS-10219, CMS-10242, CMS-10178, CMS-2744, CMS-3070, CMS-10479, CMS-10371 and CMS-R-137]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by **[Insert date 30 days after date of publication in the Federal Register]**:

ADDRESSES: When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and

recommendations must be received by the OMB desk officer via one of the following transmissions:

OMB, Office of Information and Regulatory Affairs

Attention: CMS Desk Officer

Fax Number: (202) 395-6974 OR

E-mail: [OIRA\\_submission@omb.eop.gov](mailto:OIRA_submission@omb.eop.gov)

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web Site address at  
<http://www.cms.hhs.gov/PaperworkReductionActof1995>.
2. E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to [Paperwork@cms.hhs.gov](mailto:Paperwork@cms.hhs.gov).
3. Call the Reports Clearance Office at (410) 786-1326.

FOR FURTHER INFORMATION CONTACT:

Reports Clearance Office at (410) 786-1326

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501-3520), federal Agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term "collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each

proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. Type of Information Collection Request: Reinstatement of a previously approved collection; Title of Information Collection: Certification of Medicaid Eligibility Quality Control (MEQC) Payment Error Rates; Use: These reviews are conducted to determine whether or not the sampled cases meet applicable State Title XIX or XXI eligibility requirements when applicable. The reviews are also used to assess beneficiary liability, if any, and to determine the amounts paid to provide Medicaid services for these cases. In the Medicaid Eligibility Quality Control (MEQC) system, sampling is the only practical method of validating eligibility of the total caseload and determining the dollar value of eligibility liability errors. Any attempt to make such validations and determinations by reviewing every case would be an enormous and unwieldy undertaking. During each 6-month review period, states are required to collect data on eligibility payment error dollars and paid claims dollars for each case in the sample. States must also identify cases for which a review cannot be conducted. At the conclusion of the 6-month review period, states must complete the Payment Error Rate form which contains aggregate data on sample size, number of sampled cases dropped, and number of sampled cases listed in error. These data, along with the calculated eligibility payment error rate and lower limit are certified by the State Medicaid Director (or designee) and submitted to the Regional Office. The collection of information is also necessary to implement provisions from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) with regard to the

MEQC and Payment Error Rate Measurement (PERM) programs. Form Number: CMS-301 (OCN: 0938-0246); Frequency: Semi-Annually; Affected Public: State, Local, or Tribal Governments; Number of Respondents: 51; Total Annual Responses: 102; Total Annual Hours: 16,446. (For policy questions regarding this collection contact Monetha Dockery at 410-786-0155.)

2. Type of Information Collection Request: Reinstatement of previously approved collection; Title of Information Collection: State Medicaid Eligibility Quality Control (MEQC) Sample Plans; Use: The Medicaid Eligibility Quality Control (MEQC) system is based on monthly state reviews of Medicaid and Medicaid expansion under Title XXI cases by states performing the traditional sampling process identified through statistically reliable statewide samples of cases selected from the eligibility files. These reviews are conducted to determine whether or not the sampled cases meet applicable state Title XIX or XXI eligibility requirements when applicable. The reviews are also used to assess beneficiary liability, if any, and to determine the amounts paid to provide Medicaid services for these cases. In the MEQC system, sampling is the only practical method of validating eligibility of the total caseload and determining the dollar value of eligibility liability errors. Any attempt to make such validations and determinations by reviewing every case would be an enormous and unwieldy undertaking. In 1993, we implemented MEQC pilots in which states could focus on special studies, targeted populations, geographic areas or other forms of oversight with our approval. States must submit a sampling plan, or pilot proposal for us to approve before implementing their pilot program. The Children's Health Insurance Program Reauthorization Act (CHIPRA) was enacted February 4, 2009. Sections 203 and 601 of the CHIPRA relate to MEQC. Section 203 of the CHIPRA

establishes an error rate measurement with respect to the enrollment of children under the express lane eligibility option. The law directs states not to include children enrolled using the express lane eligibility option in data or samples used for purposes of complying with the MEQC requirements. Section 601 of the CHIPRA, among other things, requires a new final rule for the Payment Error Rate Measurement (PERM) program and aims to harmonize the PERM and MEQC programs and provides states with the option to apply PERM data resulting from its eligibility reviews for meeting MEQC requirements and vice versa, with certain conditions. We review, either directly or through its contractors, of the sampling plans helps to ensure states are using valid statistical methods for sample selection. Form Number: CMS-317 (OCN: 0938-0148); Frequency: Semi-Annually; Affected Public: State, Local, or Tribal Governments; Number of Respondents: 10; Total Annual Responses: 20; Total Annual Hours: 480. (For policy questions regarding this collection contact Monetha Dockery at 410-786-0155.)

3. Type of Information Collection Request: Reinstatement of a previously approved collection; Title of Information Collection: State Medicaid Eligibility Quality Control (MEQC) Sample Selection Lists; Use: The Medicaid Eligibility Quality Control (MEQC) system is based on monthly state reviews of Medicaid and Medicaid expansion under Title XXI cases by states performing the traditional sampling process identified through statistically reliable statewide samples of cases selected from the eligibility files. These reviews are conducted to determine whether or not the sampled cases meet applicable state Title XIX or XXI eligibility requirements when applicable. The reviews are also used to assess beneficiary liability, if any, and to determine the amounts paid to provide Medicaid services for these cases. In the MEQC system, sampling is the only practical method of validating eligibility of the total caseload and

determining the dollar value of eligibility liability errors. Any attempt to make such validations and determinations by reviewing every case would be an enormous and unwieldy undertaking. At the beginning of each month, state agencies still performing the traditional sample are required to submit sample selection lists which identify all of the cases selected for review in the states' samples. The sample selection lists contain identifying information on Medicaid beneficiaries such as: state agency review number, beneficiary's name and address, the name of the county where the beneficiary resides, Medicaid case number, etc. The submittal of the sample selection lists is necessary for Regional Office validation of state reviews. Without these lists, the integrity of the sampling results would be suspect and the Regional Offices would have no data on the adequacy of the States' monthly sample draw or review completion status. The authority for collecting this information is Section 1903(u) of the Social Security Act. The specific requirement for submitting sample selection lists is described in regulations at 42 CFR 431.814(h). Regional Office staff review the sample selection lists to determine that states are sampling a sufficient number of cases for review. Form Number: CMS-319 (OCN: 0938-0147); Frequency: Monthly; Affected Public: State, Local, or Tribal Governments; Number of Respondents: 10; Total Annual Responses: 120; Total Annual Hours: 960. (For policy questions regarding this collection contact Monetha Dockery at 410-786-0155.)

4. Type of Information Collection Request: Reinstatement without change of a previously approved collection; Title of Information Collection: 1915(c) Home and Community Based Services (HCBS) Waiver; Use: We will use the web-based application to review and adjudicate individual waiver actions. The web-based application will also be used by states to submit and revise their waiver requests. Form Number: CMS-8003 (OCN: 0938-0449); Frequency: Yearly;

Affected Public: State, Local, or Tribal Governments; Number of Respondents: 47; Total Annual Responses: 71; Total Annual Hours: 6,005. (For policy questions regarding this collection contact Kathy Poisal at 410-786-5940.)

5. Type of Information Collection Request: Revision of a currently approved collection; Title of Information Collection: Healthcare Effectiveness Data and Information Set (HEDIS®) Data Collection for Medicare Advantage; Use: We use the data in the Healthcare Effectiveness Data and Information Set (HEDIS®) to: monitor Medicare Advantage organization performance, inform audit strategies, and inform beneficiary choice through their display in our consumer-oriented public compare tools and websites. Medicare Advantage organizations use the data for quality assessment and as part of their quality improvement programs and activities. Quality Improvement Organizations and our contractors use HEDIS® data in conjunction with their statutory authority to improve quality of care, and consumers who are making informed health care choices. In addition, we make health plan level HEDIS® data available to researchers and others as public use files at [www.cms.hhs.gov](http://www.cms.hhs.gov). Form Number: CMS-10219 (OCN: 0938-1028); Frequency: Yearly; Affected Public: Private sector - Business or other for-profit and Not-for-profit institutions; Number of Respondents: 576; Total Annual Responses: 576; Total Annual Hours: 184,320. (For policy questions regarding this collection contact Lori Teichman at 410-786-6684.)

6. Type of Information Collection Request: Reinstatement with change of a previously approved collection; Title of Information Collection: Emergency and Non-Emergency Ambulance Transports and Beneficiary Signature Requirements in 42 CFR 424.36(b); Use: Ambulance providers and suppliers are the primary information users. Specifically, when

ambulance providers and suppliers sign claims on behalf of beneficiaries they are required by §424.36(b)(6) to keep certain documentation in their files for at least four years from the date of service. The purpose of this information collection is to document emergency and nonemergency ambulance transports where the beneficiary was incapable of signing the claim and the ambulance provider or supplier signed the claim on the beneficiary's behalf. The information may also be used by: (1) our Part A and Part B Medicare Administrative Contractors that process and pay ambulance claims; (2) our staff who review and audit claims for medical necessity; (3) our staff who review claims for overpayments; and (4) by others who investigate ambulance billing practices to ensure compliance under the False Claims Act and anti-kickback statute. Therefore, besides ambulance providers and suppliers, the information collected may be used by CMS, the Office of the General Counsel, the Office of the Inspector General, the Department of Justice, and the Federal Bureau of Investigations. Form Number: CMS-10242 (OCN: 0938-1049). Frequency: Occasionally; Affected Public: Private sector - Business or other for-profit and not-for-profit institutions; Number of Respondents: 11,564; Total Annual Responses: 15,633,781; Total Annual Hours: 1,303,857. (For policy questions regarding this collection contact David Walczak at 410-786-4475.)

7. Type of Information Collection Request: Reinstatement of a previously approved collection; Title of Information Collection: Medicaid and Children's Health Insurance (CHIP) Managed Care Claims and Related Information; Use: The Payment Error Rate Measurement (PERM) program measures improper payments for Medicaid and the State Children's Health Insurance Program (SCHIP). The program was designed to comply with the Improper Payments Information Act (IPIA) of 2002 and the Office of Management and Budget (OMB) guidance.



Although OMB guidance requires error rate measurement for SCHIP, 2009 SCHIP legislation temporarily suspended PERM measurement for this program and changed to Children's Health Insurance Program (CHIP) effective April 01, 2009. See Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Public Law 111-3 for more details. There are two phases of the PERM program, the measurement phase and the corrective action phase. PERM measures improper payments in Medicaid and CHIP and produces state and national-level error rates for each program. The error rates are based on reviews of Medicaid and CHIP fee-for-service (FFS) and managed care payments made in the Federal fiscal year under review. States conduct eligibility reviews and report eligibility related payment error rates also used in the national error rate calculation. We created a 17 state rotation cycle so that each state will participate in PERM once every three years. We need to collect capitation payment information from the selected states so that the federal contractor can draw a sample and review the managed care capitation payments. We will also collect state managed care contracts, rate schedules and updates to the contracts and rate schedules. This information will be used by the Federal contractor when conducting the managed care claims reviews. Sections 1902(a)(6) and 2107(b)(1) of the Social Security Act grants us authority to collect information from the States. The IPIA requires us to produce national error rates in Medicaid and CHIP fee-for-service, including the managed care component. The state-specific Medicaid managed care and CHIP managed care error rates will be based on reviews of managed care capitation payments in each program and will be used to produce national Medicaid managed care and CHIP managed care error rates. Form Number: CMS-10178 (OCN: 0938-0994); Frequency: Occasionally; Affected Public: State, Local, or Tribal Governments; Number of Respondents: 34; Total Annual

Responses: 2040; Total Annual Hours: 28,050. (For policy questions regarding this collection contact Monetha Dockery at 410-786-0155.)

8. Type of Information Collection Request: Revision of a previously approved collection; Title of Information Collection: End Stage Renal Disease (ESRD) Medical Information Facility Survey; Use: The End Stage Renal Disease (ESRD) Medical Information Facility Survey form (CMS-2744) is completed annually by Medicare-approved providers of dialysis and transplant services. The CMS-2744 is designed to collect information concerning treatment trends, utilization of services and patterns of practice in treating ESRD patients. The information is used to assess and evaluate the local, regional and national levels of medical and social impact of ESRD care and is used extensively by researchers and suppliers of services for trend analysis. The information is available on our Dialysis Facility Compare website and will enable patients to make informed decisions about their care by comparing dialysis facilities in their area. Form Number: CMS-2744 (OCN: 0938-0447); Frequency: Yearly; Affected Public: Business or other for-profit and Not-for-profit institutions; Number of Respondents: 5,964; Total Annual Responses: 5,964; Total Annual Hours: 47,712. (For policy questions regarding this collection contact Michelle Tucker at 410-786-0736.)

9. Type of Information Collection Request: Reinstatement with change of a currently approved collection; Title of Information Collection: Intermediate Care Facility (ICF) for the Mentally Retarded (MR) or Persons with Related Conditions Survey Report Form; Use: This survey form is needed to ensure intermediate care facility (ICF) for the mentally retarded (MR) provider and client characteristics are available and updated annually for the federal government's Online Survey Certification and Reporting (OSCAR) system. It is required for the

provider to fill out at the time of the annual recertification or initial certification survey conducted by the state Medicaid agency. The team leader for the state survey team must review and approve the completed form before completion of the survey. The state Medicaid survey agency is responsible for transferring the 3070 information into OSCAR. Form Number: CMS–3070 (OCN: 0938–0062); Frequency: Reporting – Yearly; Affected Public: Private Sector: Business or other for-profits and Not-for-profit institutions; Number of Respondents: 6,446; Total Annual Responses: 6,446; Total Annual Hours: 19,388. (For policy questions regarding this collection contact Adrienne Rogers at 410-786-3411.)

10. Type of Information Collection Request: New Collection (Request for a new OMB control number); Title of Information Collection: Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Focus Group Protocols; Use: On September 16, 2009, the Department of Health and Human Services announced the establishment of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, under which Medicare joined Medicaid and private insurers as a payer participant in state-sponsored patient-centered medical home (PCMH) initiatives. We selected eight states to participate in this demonstration: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. We are proposing to conduct in-person focus groups with Medicare and Medicaid beneficiaries and their caregivers to more thoroughly understand patients’ experiences with their PCMHs and how well their PCMHs are serving their needs.

The focus groups will provide us with answers to fundamental “what, how, and why” questions about beneficiaries’ experiences with care and access to and coordination of care. We will use the information obtained via in-person, focus groups for the evaluation of the MAPCP Demonstration. The focus group data will be collected to supplement other qualitative and quantitative analyses from

primary and secondary data sources by providing data on context, structure, and process, as well as select aspects of the key outcomes. The data gathered from the interviews will allow for more complete interpretation of the quantitative claims and other data analysis by taking into account the unique perspectives of beneficiaries. Subsequent to the publication of the 60-day **Federal Register** notice (April 29, 2013; 78 FR 25089), the protocols have been revised by adding, revising and/or deleting questions. Form Number: CMS-10479 (OCN: 0938-NEW); Frequency: Annually; Affected Public: Individuals and households; Number of Respondents: 768; Total Annual Responses: 384; Total Annual Hours: 1,152. (For policy questions regarding this collection contact Suzanne Wensky at 410-786-0226.)

11. Type of Information Collection Request: Revision of a currently approved collection; Title of Information Collection: Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges; Use: All states (including the 50 states, consortia of states, Territories, and the District of Columbia herein referred to as States) that received a State Planning and Establishment Grant for Affordable Care Act's (ACA) Exchanges are eligible for the Cooperative Agreement to Support Establishment of State Operated Insurance Exchanges. Section 1311 of the Affordable Care Act offers the opportunity for each State to establish an Exchange [now referred to as Marketplace], and provides for grants to States for the planning and establishment of these Exchanges. Given the innovative nature of Exchanges and the statutorily-prescribed relationship between the Secretary and States in their development and operation, it is critical that the Secretary work closely with States to provide necessary guidance and technical assistance to ensure that States can meet the prescribed timelines, Federal requirements, and goals of the statute.

In order to provide appropriate and timely guidance and technical assistance, the Secretary must have access to timely, periodic information regarding State progress. Consequently, the information collection associated with these grants is essential to facilitating reasonable and appropriate federal monitoring of funds, providing statutorily-mandated assistance to States to implement Exchanges in accordance with Federal requirements, and to ensure that States have all necessary information required to proceed, such that retrospective corrective action can be minimized.

The submitted revision adds sets of Outcomes and Operational Metrics to States' data collection requirements; we will use the resulting data to evaluate Marketplace performance and overall effectiveness of the ACA. Key areas of measurement are the effectiveness of eligibility determination and enrollment processes, impact on affordability for consumers, and the effect of Marketplace participation on health insurances markets. Furthermore, these metrics facilitate actionable feedback and technical assistance to States for quality improvement efforts during the critical early period of operations. This funding opportunity was first released on January 20, 2011. Form Number: CMS-10371 (OCN: 0938-0119); Frequency: Occasionally; Affected Public: State, Local, or Tribal Governments; Number of Respondents: 40; Total Annual Responses: 1,475; Total Annual Hours: 64,695. (For policy questions regarding this collection contact Christina Daw at 301-492-4181.)

12. Type of Information Collection Request: Reinstatement without change of a previously approved collection; Title of Information Collection: Internal Revenue Service (IRS)/Social Security Administration (SSA)/Centers for Medicare and Medicaid Services (CMS) Data Match and Supporting Regulations; Use: Medicare Secondary Payer (MSP) is essentially the same concept

known in the private insurance industry as coordination of benefits; it refers to those situations where Medicare assumes a secondary payer role to certain types of private insurance for covered services provided to a Medicare beneficiary.

Congress sought to reduce the losses to the Medicare program by requiring in 42 U.S.C. 1395y(b)(5) that the Internal Revenue Service (IRS), the Social Security Administration (SSA), and we perform an annual data match (the IRS/SSA/CMS Data Match, or “Data Match” for short). We use the information obtained through Data Match to contact employers concerning possible application of the MSP provisions by requesting information about specifically identified employees (either a Medicare beneficiary or the working spouse of a Medicare beneficiary). This statutory data match and employer information collection activity enhances our ability to identify both past and present MSP situations. Form Number: CMS-R-137 (OCN: 0938-0565); Frequency: Annually; Affected Public: Business or other for-profit and Not-for-profit institutions, State, Local or Tribal Governments; Number of Respondents: 280,028; Total Annual Responses: 280,028; Total Annual Hours: 1,629,763. (For policy questions regarding this collection contact Rick Mazur at 410-786-1418.)

Dated: August 13, 2013

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Martique Jones

Deputy Director, Regulations Development Group

Office of Strategic Operations and Regulatory Affairs

Billing Code: 4120-01-U-P

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